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of both agencies/programs may be so informed and referred.

Indicate who has the responsibility for referrals, under what circumstances referrals are made, and who will have the follow-up responsibilities.

Numbers to be referred by the Medicaid agency to title V grantees will depend on the current title V capacity. In addition, Medicaid reimbursement can be used for expanding service capacity.

(g) Arrangements for Payment or Reimbursement

Specify:

- The providers, e.g., the State MCH or CCS agencies, or projects such as M&I, C&Y;
- To whom the payments will be made;
- mode of reimbursement, i.e., actual cost, customary charge, statistical visit rate, capitation, etc., and agreed-upon rates;
- reimbursement procedure including offices responsible for billing, payment and appeals;

- plans for use of Medicaid income earned by the title V grantee. Income may be used to expand existing services and/or initiate new programs under title V for low-income people.

(h) Arrangements for Exchange of Reports of Services to Medicaid Recipients

Specify what reports are needed; where they will be sent; how the data will be utilized; to whom the resulting information will be distributed; and at what intervals the reports will be completed.

(i) Methods to Coordinate Plans Relating to Medicaid Recipients

Indicate the frequency of planning sessions of the responsible units and the areas that will be included in mutual planning.

(j) Plans for Joint Evaluation of Policies

Describe in this section procedures for joint agency evaluation of policies that affect the delivery of services through title V to Medicaid eligibles, e.g., the scope of services covered under the title XIX State plan and the respective reimbursement rates payable by Medicaid and by title V for the services covered under

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the agreement. Provide for meetings, at least on an annual basis, to evaluate policies. Identify the units responsible for the evaluation, the periodicity of the evaluations, and how differences will be resolved.

(k) Arrangements for Periodic Review of the Agreements and Joint Planning for Changes in the Agreement

The responsible planning and evaluation units need to review the agreement to determine if it helps meet program goals or if changes in policy, budgets, laws, availability of resources, etc., require its revision. Specify in this section timing of review, responsible units, and procedures for making changes.

(l) Arrangements for Continuous Liaison and Designation of State and Local Liaison Staff

Describe the Medicaid-title V liaison units at the State and local levels and their responsibilities.

3 - Specific Content of Medicaid - Health Department Agreements

General Medicaid-health department agreements may cover specific arrangements for title V services in order to satisfy 42 CFR 451.10(a)(2), even though the

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health department may be the title V grantee. These arrangements may be detailed either in separate sections of the Medicaid-health department agreement or in separate agreements between Medicaid and the appropriate title V unit(s) within the health department. A "general" Medicaid agency-health department agreement is acceptable if it:

(a) includes financing and other elements that are the same for all programs under the jurisdiction of the health department, including the MCH/CCS programs, and
(b) states specifically that all such elements apply to those programs.

An agreement between the Medicaid agency and the health department (whether separate agencies or separate units within an umbrella agency) needs to specify whether the services/programs covered under the agreement are those funded by title V, or are provided under other funding and authorities available to the health department, or both.

Grants for family planning and dental health projects are made to State health agencies. Occasionally the grant goes directly to a local health department or other local agency. These projects should increase the availability of such services to Medicaid recipients, and the agreement with the State health agency would include such projects.

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4. Specific Content of Medicaid-Title V Agreements, including EPSDT Agreements

Each State must have a title XIX-Title V agreement. It should be developed by those State agency representatives specifically responsible for administering the MCH, CCS and Medicaid (including EPSDT) programs.

Title XIX-title V agreements must be statewide in scope and should include a separate section on EPSDT activities. The agreement must include those title V services and related financing arrangements which are uniform in nature throughout the State and, where applicable, supplemental agreements for specific services and related financing arrangements that are not uniformly provided.

Specific reference is made in the Medicaid law to provision, as may be appropriate, for reimbursing title V agencies, institutions or organizations for the cost of services to Medicaid recipients. The intent of this provision is to make Medicaid funds the first and primary source of payment for medical services provided Medicaid recipients through title V programs. Interagency agreements should allow for the use of each agency's funds within the limits and administrative arrangements of each program.

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Over two-thirds of the CCS programs throughout the country are administered by State health departments, and arrangements would, therefore, be covered in the basic health department-Medicaid agreement. Where CCS is administered by another State agency such as a special commission for the handicapped, a State welfare department, or a university medical school, separate agreements are needed with those agencies or organizations.

Maternity and infant care projects are intended to serve high risk prospective mothers and their infants in the first year of life. High risk refers to "any condition or any circumstance which increase the hazards to their health" (Social Security Act, Section 508)a)(1)). Projects for health of children and youth of preschool and school age in low-income areas provide comprehensive health services for young people who, because of economic or environmental circumstances, do not receive medical and related services. Mothers and children in public welfare families would qualify for care under both types of projects, and an agreement with the State health department or the State CCS agency is needed to cover such projects. Separate sections within the overall State agreement will be necessary when these projects are carried out under a local health department, medical school, teaching hospital, or non-profit private agency.

Agreements need to include not only the scope of medical services that are to be provided by title V grantees, but also related non-medical services that are to be provided by State and local operating

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agencies. These include such activities as ensuring or facilitating patient access to health services and allied health professionals; ensuring continuity and quality of care; and encouraging or promoting comprehensive evaluative procedures when appropriate.

The cooperative arrangements and the services that are to be provided by title V grantees are subject to mutual agreement by the respective agencies. They are to be described in the agreement in sufficient detail to allow for full understanding by both parties of each agency's responsibility for providing and paying for services to EPSDT-Medicaid eligible individuals.

States need to consider including in their interagency agreements the following elements to meet requirements of 42 CFR 451.10(a)(1) and (2) and 42 CFR 449.10(a)(3)(i)-(iii) for maximum utilization of State health and title V services for EPSDT eligibles:

- Arrangements for providing EPSDT services and related financing, including Statewide title V services and those that vary by program or project.

- Arrangements for title V programs and projects to provide to (or arrange for) EPSDT eligibles screening and related treatment and other Medicaid services under the plan. This will maximize continuity of care between initial and periodic screening episodes and acute care needs,

and use of the full range of preventive and comprehensive care services provided by title V programs.

- Title V provision of non-medical services. Examples are: (1) resource development and coordination, (2) outreach activities, (3) case management procedures to assure completion of all stages from early identification through follow-up and after-care activities.

In this connection, if conditions described in Section 2-41-00 of this manual and SRS Action Transmittal 76-66 (4/20/76) are met, 75 percent Federal matching under Medicaid for EPSDT health-related support services is available.

H. Financing Arrangements

Effective financing arrangements between Medicaid and the other State agencies can facilitate the development, organization and implementation of health care services for Medicaid recipients. Decisions about financing arrangements and reimbursement for services to Medicaid recipients should be worked out between the responsible agencies to make the most effective use of funds of all programs. However, the statute has given special emphasis to the use of Medicaid funds as a first dollar resource by title V.

Medicaid funds may also be used as a first dollar resource for services provided by vocational rehabilitation and certain other programs and

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projects (see section I-1). However, payment benefits from other hospital or health insurance, or other third parties which are under obligation to provide such benefits for Medicaid eligibles, must be used before drawing on Medicaid funds.

If Medicaid funds are to be used for payment of medical services, fee schedules must be established and all third parties must be billed for services covered under the agreement for which they are liable. Financing arrangements can include: a) reimbursement on the basis of fee-for-services, per-patient-visit, per-clinic-visit, and b) prepayment methods.

The State Medicaid agency may pay title V grantees, Head Start grantees and others as "providers". In such instances, Medicaid payment is payment in full and the grantee may not bill another party for additional amounts.

When a grantee is a "provider" for Medicaid purposes, Medicaid (1) is not involved in payment the grantee negotiates with its own providers; and (2) cannot require that the grantee's providers have Medicaid agreements. The grantee's payment to its provider may be higher than that which it has received from Medicaid so long as it accords with the upper limits for its own programs.

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A "provider" under Medicaid, other than the grantee, who furnishes services under a grantee program or project and receives payment directly from Medicaid, must accept the Medicaid payment as payment in full and may not bill the grantee.

Cost reporting systems are needed to determine the cost of providing specific types and units of services to Medicaid eligibles.

I. Related Issues

The interrelationships regulation calls attention to several related issues growing out of other regulations or involving questions of public assistance philosophy.

1. Medicaid as a Residual Program Along with other public assistance programs, Medicaid is considered a residual program. As such, it is intended to be a resource only after other sources of medical care have been tapped. However, greater flexibility exists in the medical assistance program than is possible in financial assistance programs. Other Federally-funded programs may have a higher residual rating than Medicaid. They are generally closed-